UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ALASKA

KIMBERLY ALLEN, Personal Representative of the ESTATE OF TODD ALLEN, Individually, on Behalf of the ESTATE OF TODD ALLEN, and on Behalf of the Minor Child PRESLEY GRACE ALLEN,

Plaintiffs,

vs.

UNITED STATES OF AMERICA,

Defendant.

Case No. A04-0131 (JKS)

VIDEOTAPED DEPOSITION OF MICHAEL LEVY, MD

Pages 1 - 195, inclusive

Friday, February 24, 2006
2:12 P.M.

Taken by Counsel for Plaintiffs
at
ASHBURN & MASON
1130 West 6th Avenue, Suite 100
Anchorage, Alaska

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more time -- I did all my emergency stuff, but I also spent more time with the internal medicine side of it as well as having my own clinic for -- I forget now. I think it was about three years while I was a resident there.

Q. And when you say your own clinic, what do -- what do you mean?

A. I had a clinic -- when you're an internal medicine resident, you have a clinic and patients you're responsible for a couple times a week during the two or three years of your residency, so you do your regular stuff, your hospital stuff, and then you would come in and see patients that have been assigned to you who would be returning to you on an ongoing basis, that you're treating blood pressure and diabetes and various such things.

Q. Are there subspecialties within emergency medicine, or were -- when you refer to subspecialties, was that within some -- some other group, some other --

A. Well, there actually are. There's -- there's gerontology, there's sports medicine, there's critical care or other fellowship boardings that you can get associated --

Q. Okay.

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A. -- with emergency medicine.

Q. In -- in regards to your board certification in emergency medicine, is it generally in emergency medicine, or is it --

A. Yeah. I'm board certified in both emergency medicine and internal medicine.

Q. All right. And I saw that you're -- you were recertified in emergency medicine in 1998. Is there -- is there a requirement that you be recertified every ten years?

A. With emergency medicine, there is.

Q. With emergency medicine. And how about with internal medicine?

A. There isn't for my year, so I just have to keep up with my CE's and the like. They do have a pathway for that, which I have been doing their CE's, but I haven't gone through the --

Q. Okay.

A. -- recertification because I don't have to.

Q. And then are you -- is your pra- -- current practice now emergency medicine?

A. Yes.

Q. Do you feel like you're practicing internal medicine? I -- I assume that there's some overlap between internal medicine and emergency medicine,

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but is -- is basically your practice comprised of -- of working in an emergency room?

A. 100 percent emergency medicine, but the training I received in internal medicine is kind of integral to that.

Q. Okay. What's -- what is the difference between the training that a family medicine physician undergoes versus emergency medicine physician? And can you be board certified in family medicine?

A. Yes --

Q. Can you? Okay.

A. -- you can. I guess I can't be real expert in talking about family medicine, what their -- their focus, though it just generally has to do more with being the medical home for people, ongoing care from cradle to grave basically, so doing pediatrics and then adolescent and adult care; and mostly focusing on, you know, health promotion, disease prevention, I think.

So taking care of chronic illness, doing the usual immunizations, kind of the whole gamut of stuff, but not looking to -- and more intense focus, like emergency medicine would with regard to the acute emergencies we see; and then less like internal

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medicine, in that internists are trained to a more specific level for adult disease and more complex adult disease, which a family practitioner would probably refer many cases to an internist or an internal medicine subspecialist.

Q. Okay. Since -- since completing your residency -- and that was four years?

A. Yes.

Q. And is that in part because you were doing the internal -- I'm sorry -- a residency in internal medicine and emergency medicine together?

A. Yes.

Q. All right. And then you were chief resident, emergenc- -- emergency medicine at McGaw Medical Center. Is -- where is that? Where is McGaw?

A. That's Northwestern University in Chicago and the Gold Coast.

Q. Okay. And that's -- and as chief resident, what generally were your responsibilities?

A. I was a fourth-year resident at the time, and so, in addition, I had a leadership role with regard to the residency, and interface with the attending staff, teaching responsibilities, and scheduling.

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Q. Okay. If you could describe for me right, currently, what is your -- what's your current practice?

A. I'm an emergency physician. I'm the chairman of the emergency medicine department at Regional. So my -- I spend a hundred percent of my time doing clinical work, seeing patients with all manner of emergency.

Q. Okay. Are you involved in training medical students through the WWAMI program or any sort -- other sort of program?

A. We occasionally have medical students, but they're not through WWAMI. They come from places like Scotland and the like, through just associations that some of our partners have had with them.

Q. Okay. So -- so have you been involved in at least training some -- some medical students who are --

A. I have trained medical students, yes.

Q. All right. How about working with people in emergency medicine -- let me go back to the first page of your CV. It says National Association of EMS -- oh, that's emergency medicine physicians. Is that correct?

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A. EMS, emergency medical services physicians.

Q. Okay. Do you work with training paramedics?

A. Yes.

Q. Okay. And -- and I guess EMTs, emergency medicine technicians. Is that what that stands for?

A. They're all -- yeah. A paramedic is technically an emergency medical technician, hyphen P, so the highest level of EMT is paramedic.

Q. Okay. And you're involved in training --

A. Yes.

Q. -- in paramedics and -- and the like?

A. I was head of the -- I was the medical director for the Paramedic Academy here in town for four or five years, and since then I am not doing that right now. And when it's become MTI with a security and that thing over there, I -- I left them then, but up till that point I was with -- Aurora North is what the academy was before, and it became NorthStar Academy.

Q. Okay.

A. And after NorthStar it became MTI. And at that time I left, but --

Q. Okay. But are you familiar with the sort of medical training the paramedics --

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A. Oh, sure.

Q. -- have?

A. Well, in addition, I'm the medical director for the Anchorage Fire Department. So I'm in charge of areawide EMS, is really my most recent title. And I'm the past chairman of the medical advisory board on EMS for the mayor.

Q. Okay. And what year was -- what year were you in that position?

A. I've been in it since 1995.

Q. Okay. So you're currently in -- so you're currently in that position?

A. Yes.

Q. Okay. And you've been doing it for the last 11 years?

A. Uh-huh.

Q. Okay. It looks like you worked at Alaska Native Medical Center from July '89 to June '90. Is that correct?

A. Correct.

Q. And then why did you end up leaving there?

A. I had a commitment to the National Health Service Corps that began after my -- after I finished my residency. It was a three-year commitment.

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Q. Okay.

A. And so it expired. And I was done with it. At that point in time, I didn't really wish to continue in the National Health Service Corps.

Q. Okay. And it's called the National Health Service Corps?

A. Yes.

Q. And what's the -- I'm sorry. What was the commitment? I'm not sure I understand that.

A. Well, I expend- -- I attended a very expensive medical school.

Q. Okay. And so you committed to work --

A. Year for year for tuition.

Q. Okay. And -- and what's the -- and you said it's a -- it's a three-year program?

A. For me, I signed on for three years. I -- because it's just the way the fourth year in my medical school was structured, it wasn't as expensive for me as the first three years. And, you know, I frankly didn't want to have any more time with the National Health Service necessarily than I had to. I didn't want to commit to that. I wanted to volunteer. I thought it was different. But anyway, so I was able to do that for three years, and that was my commitment time. So I had spent two

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with a colleague who is a -- he's a physician, JD.
Q. A physician, JD, somebody not in Alaska?
A. Not in Alaska.
Q. Okay. And what --
A. Without mentioning names or places --
Q. Sure.
A. -- or people or times.
Q. And what was your -- what was the -- the purpose of that conversation?
A. The purpose was really more or less to fill time. This is a friend who thrives on talking about such things, quite honestly, and he's got his perspectives on things. And so I think it was more just that kind of conversation.
Q. This friend of yours, does he practice -- I'm just curious if he's practicing law or practicing medicine.
A. Medicine.
Q. Okay. Is he one of the -- is he somebody who went to -- who was a lawyer and then became a doctor, or was he a doctor and then became a lawyer?
A. Doctor, became a lawyer.
Q. Okay. I don't ever see it the other way around. All right. Do you actually -- do you work for a group that works at Alaska Regional, or are

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you an actual employee of Alaska Regional?
A. We have a corporation, and we're a contractor to Alaska Regional.
Q. Okay. And is there -- how many people are in your group?
A. There are seven of us.
Q. And then are -- is there any particular hierarchy within the group?
A. There's -- it's a partnership with a partnership track, and we currently have just matriculated our -- the most recent person as a partner. And we actually have one hired person right now, so that would be the only hierarchy per se. Then we have one person we call our president.
Q. Okay. And are -- do you have a position in this --
A. I'm a vice president.
Q. Vice president, okay. Now, on the second page of your CV, under "Other Professional Positions," it says, "Medical director, AeroMed International." And what is that?
A. AeroMed International is a med-evac service owned by YK Delta Corp.
Q. Okay. And what's your -- you're the -- are you currently the medical director?

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A. I'm not.
Q. Okay.
A. I have worked with them since 2001, and I'm not currently the medical director.
Q. All right. But is it a group that you work with?
A. It's a group I had worked with until about five months ago, on projects prior.
Q. And is that what you were referring to before, that you had -- no longer have an association with this group --
A. No.
Q. -- or was that something else?
A. There's also -- MTI is the one I said.
Q. MTI. I'm sorry.
A. Yeah.
Q. What is MTI?
A. Medical Training Institute. It's the one you see in the paper these days associated with all the hubbub.
Q. With the Security Aviation?
A. (Witness nods head.)
Q. Got you. Okay. What was your -- I just wanted to get an understanding of what exactly you did. You were a medical director for AeroMed

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International --
A. Uh-huh.
Q. -- and then what did that -- what -- the medical director, what did that entail?
A. Right. Well, I established protocols and standing orders for the service, and reviewed 100 percent of the med-evacs, provided on-line medic control, and shared some of those duties with some of my partners at Denali Emergency Medicine Associates, which is my group. And I flew in the aircraft a few times. And then we would have monthly staff meetings, where I provide training and feedback.
Q. And the "staff" meaning to the -- were they physicians, or was this -- would be -- this be the paramedics, or who were the staff?
A. The crews were paramedics and flight RNs.
Q. Okay.
A. So that would be the component of those.
Q. And what -- what sort of aircraft are we talking about that were used for med-evacs?
A. The typical aircraft used when I was with them were Lear 35, Lear 36 -- there's a Lear 25 which was used sometimes. They were Citation jets. In the village, they had one Caravan with Grant

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Aviation, and then there was occasional use of, I think, a Conquest.

Q. Ever use helicopters?

A. No. Well, they could be involved in the village, in a helicopter rescue, insofar as the Army National Guard in Bethel has a Black Hawk that's stationed out there. And so that was used for some village rescues.

Q. Okay. And generally what would AeroMed International -- in this med-evac group, where would -- I mean, generally where was it operating? Bringing patients into Anchorage or taking patients outside of Anchorage?

A. Typically it's bringing patients into Anchorage, although it also flew, not uncommonly, to Seattle, in particular.

Q. Okay.

A. It's based here. There were two bases of operation. There was a base in Anchorage at Signature East, and then there was a base at Grant Aviation out at Bethel.

Q. Got it. And was it -- is it un- -- was it uncommon or is it uncommon to med-evac patients out of Anchorage to Seattle?

A. No, it's not uncommon.

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Q. And would generally patients go to the University of Washington?

A. Most often, I think, although there were other destinations.

Q. Okay. Would Harborview -- is Harborview part of the University of Washington?

A. Yes.

Q. Okay. And are you familiar with Harborview? Have you been down there?

A. I -- you know, I have been down there. I have spent no time there.

Q. All right.

A. So I'm not familiar with it, I guess is the easiest way to say it.

Q. Have you ever accompanied a patient from Anchorage on a med-evac to Harborview?

A. No.

Q. Have you ever accompanied a patient from -- who was being med-evac'd from Anchorage down to Seattle, at all?

A. No.

Q. All right. So you must be familiar with then how the med-evac planes -- it sounds like they're really airplanes -- are -- are equipped.

A. Yes.

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Q. Would that be fair to say? Okay. And are they equipped to transport critically ill patients?

A. Yes.

Q. And are they equipped to allow the administration of medication intravenously to patients?

A. Yes.

Q. And could you administer anti-convulsants to patients who are being med-evac'd?

A. Yes.

Q. How about monitoring and controlling blood pressure of a patient in a med-evac?

A. Yes.

Q. So they're equipped to do that. Is that --

A. Yes.

Q. Are they equipped to monitor and control fluids in a patient?

A. Yes.

Q. All right. In your experience with med-evacking patients from Anchorage down to Seattle, whatever that destination within Seattle would be, are the patients generally accompanied by a medical professional, whether or not it's a paramedic or a physician or a nurse?

A. What type of patient are you talking about?

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Q. You tell me. Does it depend on the patient, depend -- is that the issue? Does it depend on how the patient is and what's going on with the patient? Does that determine who goes down with them?

A. Yes, because you could have a stable transport of a patient who is going for rehab that could be wheelchair-bound and could have just an escort in a commercial aircraft. You can have somebody who couldn't go commercial aircraft but still was not a sick patient per se, but just because of logistics, having to be in a stretcher, the like -- and they might go just with some sort of medical escort.

But for the missions that we flew, by and large, they would be people who were acutely ill and needed a higher level of care, et cetera, and they would be typically flown with a crew complement of a para- -- a flight paramedic and a flight RN.

Q. Okay. A flight paramedic and a flight RN. And how -- in your experience, how common is it that patients are med-evac'd; that is, in this last scenario that you were describing with a flight paramedic or flight RN, a critically ill patient, how often does that come about where a patient's

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medicine?
A. Yes.
Q. But they're not something that you go to on a regular basis?
A. Correct.
Q. But do you consider them to be authoritative texts on emergency medicine?
A. The problem with emergency medicine is it's so all-encompassing, that if one wants specific information, it's really better to go to source information as opposed to Tintinalli or to Peter's book. I mean, it can be helpful, but it's not -- I don't think it's really definitive.
Q. Okay. And I'm not sure I understood what you said. You would go to some other source? That's what I'm not sure I --
A. Well, so if I want to find out about subarachnoid hemorrhage and I want to know more about it than what I know, then I won't go read what Judith Tintinalli has to say about it necessarily. I would go to the medical literature and -- and try to find review articles from sources just to kind of focus in on that typically.
Q. Okay. And have you done that --
A. I have --

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Q. -- in this case?
A. Yeah. I got a whole bunch of them from your expert.
Q. Oh. Gary's been sending them around to everybody. Okay.
So you have reviewed articles that were sent to you by Mr. Guarino that apparently were cited by -- that were cited by one of my experts. Is that right?
A. Yes.
Q. Okay. And have you reviewed those articles?
A. Yes.
Q. Okay. And did they in any way -- I assume you were sent those articles after you had drafted your report in this case.
A. I don't remember, to tell you the truth.
Q. Let's just assume then -- never mind. I know the answer to that question. I shouldn't have asked it.
A. I'm glad you do, because I really don't.
Q. Well, is there anything that you read in those articles that changed your opinions in this case? Let's put it that way.
A. No, I don't think so. It was great to get to read them, though, quite honestly. I mean, this

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is something that you just don't get the opportunity to go back and do that often when you're busy with lots of other things.
Q. Sure.
A. So I enjoyed going through most of them.
Q. And did you learn something that you didn't know before, in going through those articles?
A. I always learn stuff, absolutely.
Q. Well, anything stand out in your mind about -- something you were like: Gee, I didn't know that before, involving subarachnoid hemorrhage?
A. I'm sure there was, and it will come to me when I need it. But I can't tell you right now.
Q. All right. We'll revisit the topic.
A. Okay.
MS. McCREADY: Going to your report. You were looking my way. I just wanted to make sure you weren't trying to signal me about the tape.
THE VIDEOGRAPHER: No, I'm not.
MS. McCREADY: I thought, we haven't been going that long.
(Exhibit 2 marked.)
MR. GUARINO: No. She just wanted to tell you that the tape hadn't been running for the past hour so...

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MS. McCREADY: Actually, can I see that for a second, just because I want to make sure -- oh, okay.
Q. Okay. I have marked as Exhibit 2 -- this is your report, and then also attached is some -- the records that -- it looks like the records that you reviewed, you know, as well as your -- your billing in this case up until the time you wrote your report. And I just want to focus on your report for now.
First of all, let me ask you what you were asked to do in this case.
A. Well, I think I was asked to render an opinion on the care given to Mr. Allen.
Q. By?
A. By the providers in this case, Ms. Fearey, in particular.
Q. And also by the triage nurse, Ms. Ambrose?
A. I really -- I'm sure we have a contract somewhere that's spelled out. Since I looked at every piece of material, every piece of paper that was associated with this thing -- I kind of looked at the big sweep of things, so I don't remember if I specifically asked by Ms. Ambrose or not.
Q. Okay. And then were you -- do you remember whether or not you were asked to give an opinion

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have been going about an hour, so let's just take a five-minute break.
THE WITNESS: Okay.
THE VIDEOGRAPHER: Off record, 3:00 p.m.
(Recess taken.)
THE VIDEOGRAPHER: On record, 3:11 p.m.
MS. McCREADY: Thanks.
Q. Dr. Levy, when we were talking about your area of expertise and whether or not you could render an opinion about causation in this case, do you have any training as a neurosurgeon?
A. No.
Q. All right. Have you ever -- did you ever do a rotation in neurosurgery?
A. I didn't do the full rotation in neurosurgery, no. I spent some time with the neurosurgery service, but that wasn't an elective I took.
Q. Okay. Was that back in the '70s or --
A. That was back in the '80s.
Q. In the '80s, okay. Have you ever done -- I assume you performed surgery --
A. Yes.
Q. -- in -- in your capacity as an emergency room physician. Is that correct?

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A. Yes.
Q. Do you ever do brain surgery? Have you ever done brain surgery?
A. I have assisted in brain surgery. I have never been the primary operator in brain surgery.
Q. Okay. And -- and just so I can ask: Under what circumstances would you be assisting in a brain surgery?
A. Most of the time it's elective. Right now I've gone to the operating room with colleagues to see what the outcome was in a case. So I would go in and more look than assist, I guess might be more appropriate.
And the place it could happen, which I haven't been called upon, is the placement of a drain or a monitor in the emergency department when a neurosurgeon might place -- when I was in Chinle, when I was in the reservation, I was the only one there, I had the material there to perform burr holes for a subdural hematoma and that kind of thing, but never had to do it.
Q. Okay. But you don't consider yourself to -- given that experience, to have some expertise in neurosurgery, or do --
A. Absolutely not.

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Q. Okay.
A. For the surgical side of it, neurosurgery.
Q. Okay. And what's the other side of neurosurgery?
A. Well, neurosurgery involves a lot of things, like people with ruptured disks and all kinds of things that I see, that I diagnose and then hand to the neurosurgeons for definitive care.
Q. Okay. But that's something where you would diagnosis it and then refer the patient on.
A. Correct.
Q. Is that correct?
A. Yes.
Q. Do you -- are you ever in a position as an emergency room physician to provide long-term care --
A. No.
Q. -- to the patients that you see? And -- and that's no?
A. That's "no."
Q. Looking at page two of your report -- and it sounds like you are rendering an opinion about the appropriateness of the triage decision in this case. Is -- is that true?
A. Yes.

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Q. All right. And in your opinion, as you have expressed in your report, that you thought that this patient was triaged appropriately. Is that right?
A. Yes.
Q. And what is that based on?
A. Just my reading of the report, that it's a person that presented with what he described, at least, as ear and head pain, as I recall.
Q. And when you say "the report," are you talking about the emergency room visit record?
A. The -- the entire thing that I have come to call the report, which is all available information that I had.
Q. Okay. So when you say "the report," you're talking about all his medical records and --
A. No. His presentation that day, his handwritten note on the sign-in sheets, the things that would allow me to make some conclusion about what it was he was presenting with.
Q. Okay. And let me go ahead and mark this as an exhibit, because I want to be sure that we're talking about the same thing. And I'm marking as Exhibit 3 -- this is the emergency visit record from April 19th, 2003.

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I do not believe you can say that with a medical certainty.
Q. You don't think you can?
A. No.
Q. So do you think it was just then a coincidence that he presented that morning at ANMC, to the emergency room, and then later on had a bleed?
A. No.
Q. Okay. So what is your opinion within a reasonable degree of medical certainty about what exactly his condition -- actual condition was when he presented at ANMC that morning?
A. In terms of him having a bleed as opposed to having a bleed later, he could have had a pre-aneurysmal bleed -- or if he had an aneurysm at all. Certainly we don't know that. But he could have had a premonitory pain unrelated to any free blood in the subarachnoid space.
Q. And explain that: Premonitory pain.
A. He could have had, for the sake of argument -- and I -- I wouldn't concede, because there's no way for me to know. But for the sake of argument, to say that he had a subarach- -- that he had a -- an aneurysm, for example, as a cause of

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subarachnoid bleeding.
Q. An aneurysm or ruptured aneurysm?
A. Just an aneurysm.
Q. Okay. Go ahead.
A. And so the aneurysm could have changed in size. It could have stretched. It could have had a little bit of bleeding within the layers of the aneurysm which could have caused a change in -- or could have caused some kind of notice to him certainly of discomfort, without any blood, without any observable blood in any way you wanted to look at it.
Q. Okay. So one scenario is he could have had a -- an aneurysm that changed in some sense but didn't bleed but that could have caused pain. Is that correct?
A. Yes.
Q. Okay. And another scenario is he could have a sentinel bleed. Is that right?
A. Yes.
Q. And what's the -- what's a sentinel bleed?
A. It's a release of blood into the subarachnoid space. And the "sentinel" is that it is a thing that alerts the person that -- that they -- of pain of a different nature has occurred

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and that that's their blood. And so it's a sentinel event, because it allows a person to know that something's going on.
Q. Okay. And then another scenario --
A. Sorry.
Q. That's okay. And then do you think it's within the realm of possibilities that he actually had a -- a -- a bleed, you know, not just a sentinel bleed, but a bleed?
MR. GUARINO: I don't understand the distinction between those two. Are you talking volume of blood now or time, amount of blood? Otherwise, I don't understand the difference between a sentinel bleed and bleed.
BY MS. McCREADY:
Q. Well, do you understand what I mean between a sentinel bleed and a bleed?
A. No.
Q. Okay. Well, a sentinel bleed is where there's just a small release of blood. Is that correct?
A. Probably so, yes.
Q. Okay. And what is that -- is that your understanding of what a sentinel bleed is?
A. Well, I would say that most probably it's a

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little different for each event in terms of what's a little blood. But I think, in general, I agree with that.
Q. Okay. Do you think that he could have shown up at the emergency room at ANMC the morning of April 19th with the amount of blood that was seen on the CAT scan later at Providence?
A. No.
Q. Okay. Did -- and did you review the films?
A. I did.
Q. All right. Okay. So you don't think that that's within the realm of possibilities?
A. That he had that same picture at 6:00 o'clock at night, that he had -- had at 8:00 a.m., is what you're saying?
Q. Sure.
A. Absolutely not.
Q. Okay. And --
A. But let me --
Q. Go ahead.
A. -- say that if you go back to something like maybe January 23rd or something like that, in his medical record, he has a presentation that's very, very similar to the presentation he had when he showed up on the morning of the day of the big

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event.
Q. Okay. And I --
A. And to say that that was somehow different than what happened here, in retrospect, is a little hard to say and so --
Q. That's what I want to ask -- I want to ask you about that as well.
A. Okay.
Q. But let me just say on this issue of --
A. Sure.
Q. -- of what the possibilities were in terms of the morning of April 19th, 2003 --
A. Sure.
Q. -- and what he's suffering from. So -- so one -- one scenario is he could have had, you know, something change in his aneurysm with no bleeding. That's one possibility. Is that right?
A. Yes.
Q. And then one possibility is he could have a sentinel bleed. And then are you saying that there's a -- is that true, that he could have had a sentinel bleed that morning?
A. I think that's possible.
Q. Okay. And then are you saying -- go ahead. I don't mean to cut you off.

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A. But I will tell you the reasons why I think it's --
Q. Sure.
A. -- less likely.
Q. Okay.
A. He presented with -- by his account, ear pain, possibly with extension to the head. I mean, that's a little bit vague. Certainly the nurse's triage note says ear and head pain similar to what he's had many times described to other people, and that his main focus seemed to be that he had possibly an ear infection.
Q. And that's based on Nurse Fearey's record. Is that correct?
A. Right.
Q. So that's -- you're assuming that she's documented accurately --
A. Yes.
Q. -- her visit with him. Is that right?
A. I am.
Q. Okay. Go ahead.
A. Now he received a very innocuous and pretty infective treatment certainly for subarachnoid pain, Phenergan, intramuscularly, 25 milligrams. And within a very short period of time he's up and eats

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a large meal. That, in my experience, is extraordinary for someone that has subarachnoid bleeding.
And based on that, it makes me wonder whether the event that occurred was not bleeding at that point in time but something besides bleeding that perhaps ultimately did lead to bleeding.
Q. Okay. And I want to make sure I understand that. Was -- what was extraordinary to you? Was it that he ate a meal, or was it that he had some relief of pain?
A. He received no analgesics, he received no pain medication, he received a shot that was -- for a full-grown man, would be pretty small. 50 milligram- -- 25 milligrams of Phenergan is on the low side for trying to treat even somebody's nausea who was a full-sized adult.
But really, within a very short period of time, he responded to that, seems to me. He's in a well-lit room, he ate a meal, he's no longer nauseated. His pain is not causing so much pain as to make him nauseated.
And then he goes off to Sam's Club. He goes about kind of a busy day, at least, to start with, and he starts feeling drowsy. That would not be my

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experience with people with subarachnoid bleeding.
Q. Okay. And let me -- let me ask you about that. Well, usually, your experience with people with subarachnoid bleeding is you would usually admit them to the hospital if you knew they had a subarachnoid bleed. Is that right?
A. Yeah, but I practice in Anchorage, Alaska, so I don't just get to admit them to the hospital. I'm there with them typically for hours --
Q. Right. And --
A. -- because -- so I get to see what they're like during that entire period of time. It's -- we do all the diagnostics. The neurosurgeons only come in, if they come in at all to Anchorage, if they are summoned by the results of testing. And so I have had a lot of opportunity to watch at least the near-term course of these patients' progress.
Q. Okay. But I -- I guess what -- the point I was trying to make is not that you wouldn't have a chance to observe them, but certainly you're observing them in a -- in -- in a hospital setting; that is, you don't -- when you determine that a patient is -- may have a subarachnoid bleed, you don't discharge them to go walk around, do you?
A. No.

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effect of narcotics.
A. You hear that.
Q. Is that -- is that true? Is that your understanding?
A. It's written that that can happen. And by "potentiate," it just means that maybe a dose -- if you call it five, works like a six. I mean, they say potentiate. But in terms of quantitating, it's kind of hard to say.
Additionally, they're both sedatives. They will -- can cause some sedation, so it can potentiate the sedation as well. That is one of the other potentiations it has.
Having said that, again, just in terms of common practice with people who are experienced with medications, we give significant doses of medications, narcotic medications conjointly with anti-emetics, both of them significantly sedating, in people who have been taking their medications and have had break-through pain. They're not getting any better.
And to date, I personally have never had to intervene with these people in terms of -- in my own personal practice, in terms of doing something to support breathing or to reverse the effects of the drug or anything like that.

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Q. Okay.
A. So I feel like there's a pretty significant therapeutic window in these things once you have experienced it a while.
Q. Okay. Is it your opinion then that because Mr. Allen experienced some reported relief of his pain the morning of April 19, 2003, that that would rule out the fact that he had a sentinel bleed?
A. Absolutely not.
Q. Okay. Are you saying that -- or is it your opinion that because he ate a meal that morning -- or according to his wife and -- and her deposition testimony, that that would rule out him having a -- a sentinel bleed that morning?
A. No, it doesn't rule it out. It's just that if he were having ongoing bleeding, if he were showing a progressive march of ongoing arterial bleeding from a ruptured aneurysm, for example -- I just, from a commonsense standpoint, wouldn't expect him to be just quite as chipper as he appears.
He seems to be a person whose symptoms have extremely stabilized -- it's poorly put -- but who seems to have substantially stabilized. And he really seems to be doing pretty grand at that point in time.
Q. Well, let me ask about the third -- we have

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gone over that he could have had -- his aneurysm could have changed but not bled, that he could have had a sentinel bleed.
And then are you including in the possibilities that it was just a coincidence that he happened to present at the ANMC emergency room on the morning of April 19th and then just by coincidence had a bleed that afternoon, that they're completely unrelated?
A. Nothing's impossible. I think just -- that seems unlikely to me as well.
Q. Okay. So that seems -- and I guess I want to understand what -- what your, then, opinion is going to be or what it is in terms of -- and to a reasonable degree of medical certainly exactly what was going on with him that morning. Is it -- do you think it's more likely than not that he had a sentinel bleed?
A. I think it's more likely than not he had a sentinel event.
Q. And what do you mean by that?
A. Well, in that sense, I mean, I don't know if he actually bled at that time --
Q. I understand --
A. -- when he was seen.

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Q. And I understand that we don't -- I understand that you don't know for -- you know, beyond a reasonable doubt. What I want to know is, because you're an expert in this case and you're rendering opinions in this case, what you think is more likely than not. And --
A. I think what's more likely than not is that he had, statistically, an aneurysm.
Q. Okay.
A. And the aneurysm stretched or dissected slightly or did something which caused him to have discomfort.
Q. Okay. And so you think he was experiencing -- do you think it's -- it sounds to me like you're saying: I think it's more likely than not that the morning he presented to ANMC, that is, on April 19th, that he had some sentinel event. And you're defining that as something going on with his aneurysm, whether bleeding or not?
A. Yes.
Q. Okay. And why do you say that?
A. I only say it because he ultimately has a bleed. Everything else about the way he presented was, it seems, largely consistent with his prior history.

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what, when, and what did they hear.
Q. Sure. And I guess my question to you is: Given that the -- the admitting physician and the ER physician at Providence Alaska documented that they had taken a history from the wife the very same day that he had presented at ANMC, and that the report was that he had a severe headache, I'm just trying to understand -- and it seemed like you were saying, well, sure, that's consistent with what he had. And then when I asked you, did he have a severe headache that morning, you're saying, no, that's not what he said. That's what I'm trying to understand.
A. Well, I guess I'm concerned about being --
Q. Sure.
A. -- put in a position of saying things that I don't want to say. The patient himself, when he was talking with Nurse Fearey, as far as I can tell, only by what he's written down, said he had ear pain.
She says that what she heard him say was he was most concerned about the possibility of an ear infection. That's really the only near-term things that I can go from. In a bigger sense -- does that make sense, or do you want to ask me a question about it?

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Q. No. Go ahead.
A. So I believe his presentation was that. He's complained all along, throughout his entire history of having the same pain pattern you just described, of pain at his occiput, sometimes radiating up to the top, felt bilaterally -- I mean, that's -- you know, that's -- any number of places have been documented in my report that he has said that. She is in a very stressful difficult situation. In my experience --
(Videographer coughing.)
MR. GUARINO: Excuse me. Let's -- can you hear over that?
THE REPORTER: Yes.
MR. GUARINO: Okay.
BY MS. McCREADY:
Q. Go ahead.
A. Well, I think it's certainly worthwhile, and Dr. Dietz and Dr. Lee are -- are very good doctors and know -- this shouldn't be misinterpreted, but the setting in which we do this is stressful, it's noisy, there's always a lot of stuff going on. And while I think that these histories convey the general gist of it, I don't put as much credence in that, particularly in

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retrospect, and how things are flavored in retrospect. A person has a subarachnoid hemorrhage; the doctor writes down headache. It's absolutely what you're going to do.
Q. Okay. Well, here's what I -- here's, I guess, my next question.
A. Go ahead.
Q. The fact that -- okay. If somebody has a subarachnoid bleed, certainly you would expect them to have a severe headache. Is that right?
A. You know what, I had pain, something going on, yes.
Q. So if somebody's got a subarachnoid hemorrhage, you would expect them to have head pain?
A. It's just sometimes people differentiate between what they have had before and what they have now, which didn't happen in this case. But that is, again, something that I would have been very intrigued by when I have seen people like this. They are explicit with me, in telling me: This is something different.
Q. Do you know Donna Fearey?
A. I do not.
Q. Okay. Have you ever worked her?
A. No.

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Q. All right. And so your -- basically your opinions in this case are based on the accur- -- the accuracy of her note. Is that right?
A. Well, I guess that, and I can't -- it seems to me that when you look at it going forward as opposed to looking back, it seems like she saw what she saw, she heard what she heard, and that seemed consistent with this gentleman, what he was telling her -- it -- it seemed to me to be a reasonable sort of thing that happened --
Q. Okay.
A. -- regarding him.
Q. When you're -- going to your report on page two, at that top paragraph where it says, "Donna Fearey, ANP provided competent and appropriate care for this patient as he presented to her by her account of his history and findings," what do you mean by that, as presented -- "as he presented to her by her account of his history and findings"?
A. Well, there are two distinct accounts of the history, and one of them is hers and one of them Mrs. Allen's. Mrs. Allen paints a completely different picture.
Q. Right. And not just at her deposition, would you say that she paints a different picture

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before, a patient who has been diagnosed with a subarachnoid bleed, they might be in the emergency department for -- for some period of time while you're transferring their care. Is that correct?

A. Yes.

Q. Okay. And so you would -- you wouldn't -- let me ask this: Would it be below the standard of care for you to say, to a patient who's been diagnosed with a subarachnoid bleed who's under your care, that it's okay to lift heavy objects?

A. Right. I wouldn't tell them that.

Q. And why would that be?

A. It would be because it would be my suspicion that it wouldn't be a good idea. I'm not sure there's a medical study that's ever been done, is why I say it that way, but it -- it wouldn't pass the commonsense test to tell people to do that.

Q. Okay. And you wouldn't actually send them out to go walking around the street and go shopping?

A. I would not do that.

Q. Okay. And that would be below the standard of care, wouldn't it?

A. In that setting, where one had been diagnosed, it definitely would.

Q. Okay. Now, I'm sorry. It's getting so --

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it's getting sort of late, so I want to try to wrap this up. But I do want to ask you about your time line. And -- and quickly, here -- here's what I'm -- here's what my question is about your time line. I don't -- I don't have -- I certainly don't have a reason to question your conservative time line in terms of how soon this patient would be transported to Seattle if, in fact, that was -- if there was a decision to transport the -- the patient to Seattle.

What I'm trying to understand is your qualifications for -- for saying that this patient wouldn't be a candidate to be transferred to Seattle, that, in fact, there's no way this patient could have survived the subarachnoid bleed, that there would be no way, had he been diagnosed the morning of April 19, 2003, that he would have survived. I don't understand that.

A. Okay. Based on the outcome, for one, because his outcome was that he didn't survive.

Number two, I don't think there's anything that would have -- I look at it from the standpoint: What would have been done that would have changed the outcome?

So there's mention made of such things as

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Mannitol. I mean, is there a study somewhere in the medical literature that shows that Mannitol improves outcome from a ruptured subarachnoid hemorrhage? I'm not sure there is.

Subarach- -- and in terms of temporizing, it may temporize briefly, which may allow more room for arterial bleeding to occur, but it doesn't fundamentally change anything.

In fact, repeated doses of Mannitol actually make intracranial pressure higher. So you have only got the small window of time to give Mannitol. And then all the other things that are mentioned.

Well, head of bed elevated. Neurolit- -- neurosurgical literature shows that really doesn't make a difference in terms of intracranial pressure. The use of blood pressure control. Well, there's a huge variation on how you treat that. Some people would induce hypertension with hemodilution. Other people might lower the blood pressure.

Again, what -- what is the effect on outcome of those things? I mean, those have never been shown to improve outcome in this setting.

So what's to say when a person has a huge bleed in Anchorage that he's going to do well? Who's going to take care of him? Are we going to transfer

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this patient in that setting or not? I mean, to get a -- to get an accepting physician -- Anchorage neurosurgeons are not going to operate on this person at this setting.

Q. No. And in fact, if you had a loved one who had a bleed, a brain bleed, would you -- would your preference be that they be treated at a place like Harborview as opposed to a facility here in Anchorage?

A. Next question?

Q. No. I -- I'm serious. If -- if you knew someone who had brain bleed, someone you knew --

A. Yeah.

Q. -- wouldn't you -- wouldn't your preference be that they be treated at a -- and I'm not -- I'm not criticizing the care here. Let me -- let me be clear about my question.

Would it be fair to say that the University Washington, Harborview, has a more -- well, compared to what we have here, a state-of-art facility, in terms of dealing with people with aneurysm and brain bleeds?

A. I guess it's getting late, Donna, but you know, on the one hand, you won't let me be an expert on the neurosurgical side, but you want me to make

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comments about how good they are.
Q. All right. Well, I can assume what your answer is going to be, and maybe you won't like my assumption on what your answer would be.
Certainly -- certainly the expectation would be that a patient such as Todd Allen -- would it be a fair assumption that they would be transferred to -- to Seattle if, in fact, his subarachnoid bleed had been diagnosed?
MR. GUARINO: Objection. Foundation.
BY MS. McCREADY:
Q. Well, on the one hand, he's giving -- he's going to give opinions about -- hold on. Let me --
MR. GUARINO: Sure. Go -- go ahead.
MS. McCREADY: I mean --
MR. GUARINO: No, I just want to --
MS. McCREADY: Let's be -- let's be clear. Either this patient -- you know, this person -- this expert is going to give opinions about the outcome of patients in Anchorage who have aneurysms, or -- or he's not.
MR. GUARINO: Well, no. I -- I don't have a problem with asking the question and have him answer it, but -- but it makes a difference. If Todd Allen is -- is suffering from a major bleed at 3:00 o'clock

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in the afternoon that day, saying, would you rather transfer him to Washington may be a moot question. Who's going to transfer him? Who's ever going to take a patient like that?
MS. McCREADY: Sure.
MR. GUARINO: You need to provide more detail as to where Todd Allen is in this process to say, wouldn't you rather transfer him to -- to Washington? Sure. Maybe anybody would want to transfer him, but you need to define under what condition, who's going to transfer --
MS. McCREADY: I understand.
MR. GUARINO: Okay.
MS. McCREADY: I understand what you're saying.
Q. Well, let me ask: Do you have an opinion -- do you have an opinion, again, to a reasonable degree of medical certainty, what time Todd Allen or around what time Todd Allen suffered a subarachnoid bleed?
A. I would say "no later than." Is that a fair way to approach this?
Q. Sure.
A. No later than when his wife found him with sonorous respirations, when she was shaking him and

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trying to wake him up.
Q. Okay.
A. And the fact that he was becoming really more somnolent, probably in the absence of additional medications and out of the window when you would expect the medications to still have an effect. So that was about the McDonald's lunchtime, when he was pretty much unarousable, and loud snoring.
Q. That's your opinion, that that -- I mean, based on your review of the record, that's sort of the opinion you have come to, that around that time he would have suffered a bleed, or no later than --
A. Yeah. My -- my opinion at that point is that his neurological status was significantly changed at that point in time, and the reason for the change is that -- is because he suffered the subarachnoid bleed.
Q. Okay. And I'm sorry. Where did you place the McDonald's visit? Did you have a time for that?
A. I'm not sure I mentioned about McDonald's, but she had gone out for lunch and then came back. And she dined behind the partition while he -- and there's a little TV back there with a light.
Q. Okay. And is that before or after her

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phone call to Alaska Native Medical Center?
A. That was before.
Q. Okay. And how does that -- what significance does that -- that opinion about when he may have suffered a bleed, how is that significant to your opinions in this case?
A. I felt that by the time -- I mean, just in terms of what we knew later by the results of the CT scan, that when he's actively bleeding, when his neurological status has significantly declined, he is no longer a candidate for -- he is no longer that person that you can admit to the hospital, give him pain medication and operate on the next day, if that's going to happen here or elsewhere. Now he's a person who has a critical, in retrospect, life-ending bleed, and so that the whole -- the whole game has changed.
Q. Okay. But how about in the morning, when he's presenting at the Alaska Native Medical Center emergency room when he's --
A. Okay.
Q. Would you agree that he was neurologically intact at that point?
A. Seemed to be.
Q. Okay. And do you know whether or not the

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section that says, "What about life preserving interventions..."

It says, "Therefore, there is no reason to believe that even under the 'best of circumstances' he would have survived this catastrophic event."

And in fairness, isn't that outside of your area of expertise?

A. Only insofar as my own experience. But in terms of being able to look at a broad scope of patients that I treat on a daily basis, perhaps. But people that I have seen with subarachnoid hemorrhage, such as what he presented with, ultimately we know that he had a surreal -- severe edema, which was ultimately life ending, that that is where I come to that conclusion.

Q. Right. And in -- but in terms of the course of -- and what I'm trying to understand is -- is linking this in the morning visit, where he's neurologically intact at ANMC and then -- well, you would agree with me that he didn't have any treatment, aside from a shot of Phenergan, the morning of April 19, 2003. Is that right?

A. Sure.

Q. So I mean, not only did he not get medical treatment, he -- I mean, he was given a shot of

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Phenergan. Would you give a shot of Phenergan to a patient who had a subarachnoid hemorrhage?

A. No.

Q. And did you say no?

A. "No." I might in addition to other things, and that might be all I did for him, actually, if all the problem was was vomiting and -- but that wouldn't be the only therapy I might think of, if that's what you're asking.

Q. Right. Well, you wouldn't give him a shot of Phenergan and send him home. Is that correct?

A. If I knew that they had a subarachnoid hemorrhage, I would not give him a shot of Phenergan and send him home.

Q. Okay. And so Mr. Allen was given a shot of Phenergan and essentially discharged. And -- and from there, you know from his wife's testimony that he walked around Sam's. Is that correct?

A. Yes.

Q. And that then -- then did you note that he had unloaded the truck --

A. Yes. He helped in unloading.

Q. -- at the hotel where they were staying?

A. Yes.

Q. All right. And that then he just laid down

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and went to -- went to sleep. Is that your understanding?

A. Yes.

Q. Okay. And certainly he didn't -- he didn't get any sort of medical intervention, is that right, except for the Phenergan?

A. Right.

Q. Okay. So are you really in a position to testify -- is this within your area of expertise, that a patient who has got a subarachnoid bleed who didn't undergo medical treatment, that there would be really no chance of their surviving?

A. I say this in context of what happened with him. He didn't survive. His ultimate end point was where it ended up, which was of having massive ongoing subarachnoid hemorrhage with cerebral edema.

Q. Okay. When you say "massive ongoing," that -- I think I don't understand that. What was the ongoing part?

A. Well, enough to fill up his entire brain pan with blood, so "massive" may be sort of an exaggeration. I don't know how you say massive. That's a bad choice.

Q. Okay.

A. But enough blood to end his life. That's

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massive enough, I guess.

Q. Right. And then when you said ongoing, that's what I'm not sure I understand, the word "ongoing."

A. Well, something had to happen to cause it to bleed and basically fill the -- it wasn't just a little bleed. He had a significant subarachnoid hemorrhage.

Q. Right. But are you saying that that was just bleeding all day long or did --

A. I --

Q. -- that happen as --

A. I clearly wouldn't be qualified to say one way or the other --

Q. Okay. And you're --

A. -- whether it was one huge spurt or whether it was ongoing bleeding.

Q. Okay. And you're not qualified to say how long it would take to develop the edema that was seen on the scans --

A. That's correct.

Q. -- at Providence that day. Is that correct?

A. Yes.

Q. So do you -- so do you really think you're

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look at the pain assessment that Mr. Allen filled out, because there were a lot of questions about what was presented in there.

A. Okay.

Q. It's exhibit -- well, I don't know what exhibit --

A. I have 8.

Q. Eight, okay. I -- I have it from the prior deposition, but I think we're using the same form. And there were questions about the effectiveness of Mr. Allen's medication. I'm not going to go back through those, but I do want look at what he described his pain as when he filled this form out. Do you see that, page two, 16a?

A. Correct.

Q. So when he was actually filling out this -- this form, whether he was on medication or how much medication he had taken, we don't know, but -- but he was at the clinic. What did he describe his pain as right then when he was filling out the form?

A. Five.

Q. Five out of ten --

A. Right.

Q. -- correct? Okay. And then he was asked: What's your pain at its worst? And what -- what did

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he say?

A. Ten.

Q. Okay. And what he did he say his average pain that month was when he was taking all of his pain medication to control his pain? What was his average pain?

A. Six.

Q. So even with the pain medication that he was taking, his average pain was a six?

A. Yes.

Q. And how many flare-ups of pain did he indicate he had had in the past months?

A. Sixteen.

Q. Okay. Would that indicate to you that his pain medication was controlling his pain, or not?

A. No.

Q. If it was controlling it, would you expect him to have frequent flare-ups of pain?

A. No.

Q. And then let me -- I'm not going to go back -- God, help me, I'm not going to go back through all the questions about -- about treatment and what treatment was provided, but let me start -- and I'm not going to go back to testimony. But you testified about the time period in the afternoon

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when you believed that he had this -- I won't use the word "massive" bleed -- large bleed, and you said the latest -- no later than when he was having -- his wife was trying to wake him up and she couldn't physically get him to -- to respond.

And then you talked about: But it could have been as early as when the McDonald's lunch -- and I'm -- I'm not going to go through the time, but that's the -- the time window.

And so my question: Let's assume that sometime in that period he had this large bleed that led him to have this neurological sort of deterioration in his condition.

In your report, you address the question of whether the phone call that was made to ANMC at 3:47 would have changed his outcome. And I don't want to go through all that, but we've had all the testimony about Mrs. Allen saying she called ANMC; the record in the hotel indicates it was sometime about 3:47. I may state that inaccurately. But it was approximately that time. And she called them. There was the discussion. And she was not told to bring Mr. Allen down to -- to ANMC or to call 911 at that point.

Was -- is it your opinion as expressed in the report that that would not have made a difference in

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his outcome at that point?

A. I don't think it would.

Q. And is that because, without going into all the testimony, because he was already actively bleeding?

A. Yes.

Q. All right. And the other questions about the time line, in terms of whether Mr. Allen was diagnosed or -- that morning, and given his condition later, would -- if he had been actively bleeding that afternoon, do you have an opinion as to whether he would have been med-evac'd to Seattle for whatever specialized treatment they could provide there?

MS. McCREADY: Objection. Foundation.

MR. GUARINO: And could you explain to me what the question -- what the foundational objection is?

MS. McCREADY: Well, it's what I've been trying to make the point about whether or not Dr. Levy is really the appropriate expert to testify about, you know, what -- whether or not -- I mean, what -- what treatment would be rendered to a patient who has been diagnosed with a subarachnoid hemorrhage.

MR. GUARINO: No, no. I'm not talking about

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what treatment he would get once he got down there or how specialized it was. I'm talking about the physical action of -- of med-evac- -- he's -- he's probably the best expert in the state on med-evacking of patients.

So that's my question, is whether a patient -- assuming Mr. Allen was in the state where he was actively bleeding and was in the neurological state that he appeared to be that afternoon, would he be med-evac'd out to another state for medical treatment at that point?

THE WITNESS: And again, that would be my opinion from that standpoint, that if he were an extremist, as he seemed to be here, we would not transport him to another state.

BY MR. GUARINO:

Q. And the time line as you presented it, in terms of his initial presentation in the morning and the -- the sort of estimates of time it would take to work him up for the day, would he have arrived -- had -- had a decision been made to med-evac him, would he have arrived in Washington, the state of Washington, whether it was Seattle or Harborview, whatever facility he might have gone to, would he have arrived in time -- before he began to bleed

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from that subarachnoid hemorrhage?

A. The estimation I can make from this: He would not have.

MR. GUARINO: Okay. It's too late to go through any other parts of your report, but I just want to make a note for the record that I'm not going to go through his report today. You've had the opportunity to look at it and question him about it.

But I will state again: To the extent there are opinions expressed in there to which Dr. Levy is qualified by training or experience to render opinions on in terms of medical care or in terms of practical experience, in terms of time line or med-evac procedures, you can expect that we'll -- we can offer him -- we will offer him or we -- we may offer him to testify on those. Nothing further.

FURTHER EXAMINATION

BY MS. McCREADY:

Q. Okay. Let me just follow up very briefly. On the pain assessment, on the patient initial assessment, which is Exhibit 8, what -- that page that Mr. Guarino was asking you about.

A. Yes.

Q. And it says, pain as it is now, pain at its worst, pain at its best.

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First of all, did -- did you ever receive Mr. Allen's work records? Do you have an understanding about whether or not he was employed?

A. I knew that he -- or I think I knew that he worked in a capacity for oil spill cleanup in Valdez, and he was off his meds for a period of time, on his meds for a period of time.

Q. Okay. And do you have any idea, before you filled this document out, whether or not he had been working in Valdez and not taking his pain medications?

A. I assume he was.

Q. You assumed he was --

A. Right.

Q. -- working? Is that what you -- is that what you meant? Okay.

A. I thought he was.

Q. And then with this -- where it says, "Frequency of pain flares during the last month," and it says "estimated 16," had you seen any visits that Mr. Allen had made in the past month to the ER complaining of pain?

A. In the month of January?

Q. Uh-huh.

A. I don't believe -- well, he was there on

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the 23rd, wasn't he, with -- and he's complaining of pain at that time. It wasn't the ER. It was the clinic.

Q. It was the clinic that he went to?

A. Yes.

Q. Was he at the emergency room complaining of pain --

A. No.

Q. -- in that past month?

A. No.

Q. Okay. When it says, "Pain at its worst," a ten out of ten, do we know whether or not his pain on April 19, 2003 was the worst pain he had ever had?

A. No.

Q. Well, do you know whether or not it was worse than when he -- it was worse than the pain he described when he filled this document out?

A. I don't know. I -- I routinely have people tell me they have 12 out of 10 pain and 13 out of 10 pain. So I don't know if he would exaggerate that way -- you know, if your -- if he needed more volume on the thing, but as far as I can tell, from the information I have, I have no way to say.

Q. Okay. You -- you can't say whether or not,

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when he -- when he presented at April 19, 2003, that was the worst pain he had ever had, and in fact, worse than what he described in his pain initial assessment form?

A. No.

Q. All right. When Mr. Guarino was asking you about would Mr. Allen have been a candidate to be med-evac'd down to Seattle if, in fact, he had had the -- as -- as he presented that afternoon at Providence, that is, with significant blood in his brain, and you said no, he wouldn't have been transported, would that be your call or would that be the call of a neurosurgeon?

A. Well, ultimately I would engage someone to share that with me.

Q. Okay. And who --

A. Now, I don't know it would be a neurosurgeon -- in this situation, quite honestly, it would probably be Dr. Kohler, if he was in town back then. I think he was.

Q. And is Dr. Kohler the neurosurgeon at ANMC?

A. Right, who did not perform this kind of surgery. But I believe -- and I -- I have to -- I would have to confirm this, but I believe he was in town.

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As a consequence, ANMC would want to have the final say, particularly if someone wanted to transfer their patient, Mr. Allen, to Seattle. And in the past, they have been very conservative.

I can tell you, for example, with burns, if we have burns that are over a certain percentage body area, that even if the person's alive and talking to you but has very low probability of survival, it's preferred that they stay here in Anchorage and die here.

Q. Does that end up then being your call or -- again, your call in terms of your decision about whether or not the patient is transported, or does it end up being -- does -- would ANMC, in that situation, then rely on the emergency room physician to make that decision about whether or not it makes sense to transport that person to Seattle?

A. In this specific case, I mean I would play out the scenario, too, that I would eval- -- If the person were in my care, then I would evaluate him. If I had the same findings, for example, over at Providence, then I would probably contact the neurosurgeon at ANMC, if there were such a person, and talk with them, get their opinion.

Q. And was Dr. Kohler the neurosurgeon -- was

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he at ANMC at the time that Todd Allen presented to ANMC?

A. That's that I'm saying. I don't really know.

Q. Okay.

A. I would have -- you know, go back and look at records and things, see when he came to town.

Q. Okay. If Mr. Allen had been stable, that is, neuro- -- neurologically intact and stable, would there be any question that he would be transported to Seattle?

A. The only question would be whether or not the local neurosurgeons would get involved in his care.

Q. Okay. And can you say whether or not the local neurosurgeons would get involved in his care?

A. There was a period of time when they wouldn't. And I don't know if this particular time, when he presented, was that time. There was a period of time when they were doing basically no aneurysm surgery up here.

Q. Okay. And do you have any -- do you know when they started doing that?

A. No. I was -- actually tried to find that out, and I wasn't very successful yet.

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Q. How --

A. And I still --

Q. How did you try to find that out?

A. I tried to see if I could get the neurosurgeons to look at their billing records for me to see if they were billing any aneurysm surgeries.

Q. And let me guess that you couldn't get them to do that.

A. (No response.)

Q. Okay. Were you -- did you talk to any of the neurosurgeons in town about this case?

A. Not this case per se. I talked to them in generalities without any reference to anything, just about, you know, would you operate on such a person as this or that?

Q. And what did you learn?

A. That unless -- that no one does emergency surgery in this town for aneurysms.

Q. That no one does emergency surgery in this town for aneurysms. That's what you learned?

A. For subarachnoid -- for -- for cerebral aneurysms.

Q. Sure. And was that the case in 2003?

A. And in terms of -- by "emergency surgery,"

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I mean, you know, 5:00 o'clock in the afternoon with a diagnosed subarachnoid hemorrhage in a person who is -- pick your Hunt & Hess. They are not going to go to the operating room in this town, as far as I can deduce, and in my own personal experience. It's always: Get your A team on the job, schedule it for 8:00 a.m. tomorrow morning, and then we will do it.

Q. All right. And was that the case in 2003, as far as you know?

A. The problem in 2003 again is that there was this -- this time in our medical history when neurosurgeons were not routinely taking call at the hospitals and were not doing aneurysm surgery in this town.

Q. **And the neurosurgeons being Dr. Kralick,** Dr. Godersky, and Dr. Cohen?

A. Correct. But even if Dr. Kohler were in town at that time, he didn't have privileges at the other hospitals to perform such surgeries, nor did he have backup to perform them. So effectively no one who had the skill would do those surgeries up here during a period of time which may have encompassed the time when Mr. Allen had his problem.

Q. Right. And you -- you're not comfortable rendering an opinion about whether or not it would

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be more desirable for a patient with a ruptured aneurysm to have care down in Harborview versus up here?

A. I can tell you that I know of many patients who have very good outcomes for aneurysm surgery done in Anchorage, Alaska.

MS. McCREADY: Okay. I don't have anything else. Thank you.

MR. GUARINO: Nothing else.

MS. McCREADY: Only because I'm so tired.

THE VIDEOGRAPHER: The deposition is concluded. We are off record at 5:36 p.m.

(Proceedings concluded at 5:36 P.M.)

(Signature reserved.)